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AUTHOR Zigler, Edward
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ABSTRACT

Two papers, one on child abuse and the other on effects of preinstitutional history and institutionalization on the behavior of the retarded, are presented. In the first paper the author stresses the need to document the scope and nature of child abuse in American society and discusses the difficulties in defining where on the continuum discipline ends and child abuse begins. Some characteristics of situations in which child abuse is likely to occur, such as the working single parent home, are cited. Courses in parenting are suggested as part of the effort to reduce child abuse. The author finds society's willingness to accept corporal punishment as an acceptable means of discipline at the root of the child abuse problem. Six suggestions for reducing abuse are provided. The second paper focuses on the impact of institutionalization on the behavior and development of retarded individuals. It is contended that three classes of variables determine the effects of institutionalization: they are individual characteristics, the nature of the institution, and measures of the behavioral status and growth of retarded persons (including both cognitive and motivational factors). The importance of the institutional variable is stressed, and incorporates areas such as demography, social/psychological characteristics of the institution, administrative structure, employee attitudes, and actual resident care. Results of several studies are provided. (PHR)

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Controlling Child Abuse in America: An Effort Doomed to Failure

and

Effects of Preinstitutional History and Institutionalization on the Behavior of the Retarded

lectures presented by

Edward Zigler, Ph.D.
Chairman, Department of Psychology
Yale University

for

Meyer Children's Rehabilitation Institute
University of Nebraska Medical Center
Omaha, Nebraska

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Introduction

In his lecture, Dr. Zigler asks, "When will decision makers learn that our ability to help individuals cannot outdistance the relevant and valid information we have about them?" As we look at Dr. Zigler's distinguished record in research, teaching, and public service, we see that he has been deeply involved in both the gathering of "relevant and valid information" and the design of social action strategies. He was a national level planner and evaluator of Project Head Start, and is a former director of the federal Office of Child Development.

In the Mary Elaine Meyer O'Neal Award lecture, "Controlling Child Abuse in America: An Effort Doomed to Failure," Dr. Zigler addresses the problem of child abuse in a broad social context.

As physicians who confront the very real consequences of child abuse in our young patients, it is useful to view the problem through the broader perspective Dr. Zigler affords. The feeling of outrage and protest at the victimization of helpless children cannot be denied; it is altogether appropriate. Dr. Zigler's insistence on the importance of documenting the scope and nature of this problem should spur us to assume responsibility in this regard. By so doing, we can help set the stage for the kinds of social changes that will get at the roots of this growing national problem.

The second presentation published here is a paper Dr. Zigler presented while in Omaha. The paper reflects its author's long-standing interest in and commitment to research into the impact of institutionalization on the behavior and development of retarded persons.

Jack Trembath, M.D.
MCRI Pediatrician

Controlling Child Abuse in America: An Effort Doomed to Failure

Child abuse is an area of concern that one has great difficulty approaching objectively and analytically. It is a phenomenon that arouses moral outrage and other intense emotions associated with a number of poorly understood prejudices and anxieties. Allow me to give an example from my own experience of the common revulsion toward child abuse. To highlight the cultural relativism of most moral strictures, I have asked my students what particular behavior they can think of that is inherently evil as assessed by any and all value systems. A behavior regularly nominated as the ultimate of evil is the physical abuse of defenseless child. It is interesting to me that these enlightened Yale undergraduates, who characteristically are willing to find so many reasons for socially-unacceptable behavior as to excuse the perpetrators, cannot bring themselves to view the child abuser as another victim of social forces beyond his or her control.

The great revulsion toward child abuse might help to explain why so many people react to child abuse with the psychological mechanism of denial, i.e., either disbelieving that it takes place or that it takes place too rarely to constitute a major social problem. Even leading workers in the area of child abuse have called into question the view that child abuse is an extensive problem. Yet to me there is no question that we do have a national problem of child abuse. The real question has been made murky by a failure to state whether one is making judgments on the basis of absolute or relative numbers. Certainly one can point to other negative events experienced by children such as falls which occur more frequently than does child abuse. Thus speaking relatively, one can argue that child abuse is not as large a problem as are childhood accidents.

It is my view that such a relative approach to the designation of social problems has serious dangers. Taken to its extreme, the comparative approach would lead to total inaction in most of those problem areas in which child advocates are currently working to improve the status of America's children. I therefore support the absolute approach to the problem of child abuse and argue that whether there are one-thousand or one-million abused children, child abuse constitutes a real social problem that merits our society's concern and intervention.

Whatever arguments exist in the child abuse area, there is general agreement that theoretical and empirical research efforts in this area remain primitive and rudimentary. The work done has been relatively recent, relatively limited in regard to quantity, and poor in regard to quality. It is the poor state of theory and research in the child abuse area that partially led me to the pessimistic and apocalyptic title of this address. I believe that there is a logical relation between the knowledge base in an area and the ability of workers in that area to mount effective interventions. Stated most baldly, I feel that the knowledge base in the child abuse area is much too limited to direct us to any socially acceptable and realistic interventions of far-reaching effectiveness.

I am thus greatly troubled by the restrictions placed on research funding in the Child Abuse Prevention and Treatment Act of 1974. I am afraid these restrictions reflect the negative attitude concerning behavioral science research currently in vogue in the Congress. When will decision makers learn that our ability to help individuals cannot outdistance the relevant and valid information we have about them? The emphasis on services

contained in the bill partakes of the Washington dictum, "Don't just stand there, do something." I would suggest that at certain junctures in history the wiser course of action might be, "Don't do anything, just stand there." If there is anything that must be done first and done quickly in the child abuse area, it would be the development of the knowledge base that is a prerequisite for cost-effective interventions. Since the research money provided in the Child Abuse Act is much too small for the task I have outlined, we must look elsewhere for the necessary research funds. I therefore call upon the National Center on Child Abuse and Neglect to use its pivotal position in HEW agencies (e.g., NICHD, NIMH, and OE) are used to support research in the area of child abuse. OCD has played such a successful coordinating role around the issue of early childhood education. It could and should do the same for the area of child abuse.

I must add that it would be absurd to delay action until the last bit of scientific evidence is in, and I implore you not to use the relatively poor quality of scholarship in the child abuse area as an excuse for inaction. Poor though our knowledge base might be, we already know more about effective intervention that we are implementing in our social action efforts. At this level the problem is less one of inadequate knowledge than of our society's lack of resolve and commitment of resources to services known to be effective in reducing the incidence of child abuse.

Given the embryonic state of knowledge in the child abuse area, it is not surprising to discover the area more replete with myths than well-validated facts. The danger here is that when the emphasis is on social action, as it currently is in the child abuse area, these myths become the guides to action since they are all that are available to inform social policy and/or intervention efforts. Since we have only recently turned our attention to the phenomenon of child abuse, one myth has grown that child abuse has but recently appeared on the human scene. The fact of the matter is that the physical abuse of children has been commonplace for many centuries, and it is less common today than it was during any earlier century. I consider the implications of this fact to be ominous in regard to our current efforts to reduce child abuse in America. This long history of child abuse has left an historical residue which makes the physical punishment of children an acceptable social form.

Of course our immediate concern is whether child abuse is currently on the increase or on the wane, and for this we have no very reliable data. But there is a strong supposition that child abuse has increased over the past two to four decades. The Center for Child Abuse and Neglect at OCD will be performing a real service if it would continuously collect reliable data on the incidence of child abuse. There has been much discussion in the social science area concerning social indicators. I would propose the incidence of child abuse in our society as one such important social indicator.

The most telling single indicator that the child abuse area is at an extremely primitive level of theory construction is the fact that there is today no widely accepted definition of child abuse. Resolution of this definitional dilemma must become the first item of business among workers in the child abuse area. How does one investigate a phenomenon that has no widely accepted definition?One finds in the literature a vacillation between a narrow definition emphasizing serious physical abuse, a somewhat broader

definition emphasizing maltreatment, and a broad definition such as Alvy's which focuses on the fulfillment of the child's developmental needs. Alvy's comprehensive definition has considerable appeal for me since it not only flows unerringly from a sense of what children are and what they need, but also quickly leads to a plan of action for improving the lives of many vulnerable children who are at risk not only of child abuse but of a myriad of socially-sanctioned practices which interfere with the fulfillment of their developmental needs. I am aware of how threatening Alvy's definition of child abuse would be to our society since inherent in it is the view that to the extent that we silently allow ills to befall our nation's children, we are all guilty of child abuse.

A major subproblem in the definitional dilemma is the determination of at exactly what point on the punishment continuum does discipline end and child abuse begin. Related to this perplexing problem is our lack of a differentiated and conceptually-based classification system for child abuse. I believe we have gotten about all the mileage we can out of the simple two-category system we have been employing in which we essentially discriminate between children who suffer child abuse and those who do not. Perhaps there would be some profit in searching for the correlates of circumscribed types of child abuse. A number of subcategories immediately come to mind, e.g., punishing a child to the point that he is physically damaged, torturing a child, sexually abusing a child, or starving a child. At a somewhat higher level we might conceptualize a classificatory system that differentiates between acts of commission, which currently are used in the narrow definition of child abuse, and acts of ommission, which are currently employed to define child neglect as distinguished from child abuse.

Unfortunately both the old and my recommended new classificatory systems for child abuse seem to place total emphasis on behavioral acts emitted by an adult and experienced by the child. While this has certain value for the tight formation of operational definitions, I believe this value is purchased at too high a conceptual price. What appears to be missing is any concern with the adult's intentions, or any recognition that child abuse is a phenotypic event having a variety of causes.

In this same vein, much of our work in the child abuse area is a matter of treating symptoms rather than causes, an issue related to the primary vs. secondary prevention of child abuse. Primary prevention refers to the prevention of physical abuse before it occurs, while secondary prevention is after-the-fact intervention. My reading of the current social scene is that our society is willing to engage in secondary prevention but is almost totally disinterested in primary prevention. It is this state of affairs which once again leads me to be pessimistic about our country's ability to solve the child abuse problem.

Primitive though the work in the child abuse area may be, some tentative information does emerge. Studies on the psychodynamic and socio-cultural characteristics of abusing parents present considerable evidence that child abuse is more frequently found in a single (female) parent home in which the mother is working. Further, the abusing mother in such homes experiences considerable stress which is exacerbated by her sense of isolation and separation from any effective social support system. At a somewhat more tentative level, there is evidence that the working and lower SES classes are overrepresented among child abusers, even after corrections are made for the well-known SES bias in the reporting of child abuse. Certainly a warning is in order that such a finding should not be used to further disparage the poor in our nation. The over-riding majority of

economically-disadvantaged parents do not abuse their children, whatever definition of abuse is used. Yet the SES-child abuse relation is an intriguing one. A promising line of research here would be to investigate further the willingness of different SES groups to engage in physical acting -- out behaviors. Another approach would be to examine families of differing SES for variations in amount of stress experienced. It may be that the amount of stress a family experiences rather than its preferred child-rearing practices mediate the relation between SES and incidence of child abuse.

One area in which we already have convincing evidence is that an unemployed father in the home is associated with a higher incidence of child abuse. I therefore need to await no further research to assert that if our nation really would like to decrease the incidence of child abuse, it should pursue a policy which would provide employment for those who want it. Here again you must see the reason for my pessimism concerning our nation's commitment to reducing the incidence of child abuse. How can I be sanguine when I see a calculated government policy which allows a national unemployment rate of over 8 percent? I wish to be fair. Those decision makers who argue that our high unemployment rate is the cost we must pay to reduce inflation are not evil people consciously bent on the abuse of America's children. They may feel that inflation is also detrimental to family life, and this concern must have priority over the concern of unemployment.

The unemployment-inflation and child abuse issue leads me to urge decision makers to consider the health of families as a variable in their cost-benefit equations that lead our national government to pursue one course of action rather than another. We have no explicit family policy in America, and we have yet to begin the critical task of determining the impact on families of the policies implemented by our political leaders. My reading of the child abuse literature is that the single overriding factor in determining whether a child will experience abuse is that child's family's viability and strength. How can our nation control child abuse if it currently is not even taking into consideration the strength of America's families and how a variety of social policies influence this strength?

In terms of implications for effective intervention, the literature on the characteristics of abusing parents provides us with the important finding that abusing parents often have unrealistic expectations about what behaviors their children are capable of and/or a general lack of knowledge concerning the development of children. It thus appears that anything we can do to teach the general population about child care and the normal course of child development would be helpful in reducing child abuse. I thus endorse the suggestion of many workers that our nation commit itself to teaching parents how to be parents, with courses on parenthood becoming part of the curriculum of every high school in America. A model of such an effort is the Education for Parenthood program mounted jointly by OCD and OE, and this program should be greatly expanded to reach all students.

I endorse the national implementation of courses in parenting not only because I think they will be effective in reducing child abuse, but I know that the cost of such a program is relatively small. Further, thanks to the work of George Hecht and others, I believe our society is prepared to support an effort to train all our young people to become better parents. This does not mean that I would not expect some rumblings on the right concerning government subsidized education for parenthood programs. We can anticipate the charge that government is intruding itself into the nation's rearing of children. The credence given to such a charge will depend on how successful we are in constructing courses for parenthood that eschew the

inculcation of values and emphasize instead hard information concerning the development of children.

Allow me to make the point here that I am not recommending courses in parenthood for the economically-disadvantaged alone. Training in parenthood is needed by all of our young people regardless of their economic circumstances. Think for a moment about the fact that abusing parents tend to have unrealistic expectations of their children. A parallel phenomenon can be found in the middle calss, where so many parents want to teach their children to read at age two, or believe it is possible to raise a child's IQ by 20 points or more. I consider much of this phenomenon a form of child abuse, since it is characterized by a lack of knowledge about children and unrealistic expectations of them. The child who cannot fulfill these expectations must encounter a lesser degree of acceptance on the part of his parents.

Just as considerable work has been done on the characteristics of the abusing parent, a somewhat less but still substantial amount of work has been done in an effort to describe the characteristics of the child who is prone to being abused. A relation has been found between child abuse and the child experiencing the abuse being mentally retarded. We do not know how to interpret this relation. Do parents physically assault these children because they are retarded or do children become retarded as a result of being abused? If it is substantiated that a sizeable number of retarded children are abused, this might be related to the fact that abusing parents have unrealistic expectations concerning their children.

Another finding is that repeated report that premature children experience a heightened incidence of child abuse. Perhaps the very nature of premature birth produces considerable general stress in a family's life, and it may be this general stress phenomenon that mediates the relation between prematurity and child abuse. Also, premature infants probably do emit a higher incidence of noxious behaviors such as crying, and it may be such unpleasant behaviors that precipitate the parents' abuse.

But again we need await no lengthly program of research to assert that we can reduce the incidence of child abuse in America if we were willing to mount a national effort to reduce the incidence of premature births. One would want to do this for many reasons in addition to its impact on the incidence of child abuse. Yet I do not see any great national concern nor any massive intervention effort dealing with the problem of prematurity. While we already know how to markedly reduce the incidence of prematurity, what is lacking is the resolve and the commitment of the required resources.

We come now to what appears to be the most salient conceptual issue in the child abuse area, namely whether child abuse is best conceptualized as a pathological phenomenon most appropriately understood in terms of the character traits and/or psychodynamics of individual abusing parents, or whether it is most appropriately viewed as a socio-cultural, ecological phenomenon in which the causes of child abuse are viewed as residing in the extremely stressful nature of the abusing parent's ecological niche. Within this latter emphasis special attention is given to the effects of poverty, alienation, and the lack of an effective social support system for the parenting function.

How this individual vs. social conceptual issue is resolved has real implications for the social efforts we choose to mount in order to reduce the incidence of child abuse. If we commit ourselves to the individual psychopathological approach and select psychiatric intervention as the treatment of choice, I can inform you that there is not enough money nor

numbers of mental health workers to treat all the adults guilty of even gross and severe child abuse. Another intervention implication within the individual approach is that child abuse is something of a trait with which the abuser needs help in dealing. I believe that workers in the child abuse area have been too impressed with the phenomenon of abusing parents sometimes coming forward to ask for help for themselves. It is a short step from this notion to the implementation of parents anonymous groups and the establishment of hotlines. I feel that such interventions will prove ineffective because they are based on an inadequate conceptualization of causes of child abuse. My colleagues Urie Bronfenbrenner and Julius Richmond have convinced me that efforts such as these which do nothing to improve the ecological system impacting on child abuse will be ineffective.

In my opinion it is already too late in the day to view child abuse totally from the individual perspective. We must concern ourselves with the social factors which contribute to the incidence of child abuse. I personally believe that the ultimate model to be developed for explaining child abuse will be an interactive one in which the child abuser will be conceptualized as a part of a family which is itself embedded in the social, economic, and political realities of the family's ecology. But if child abuse is in large part caused by general ecological factors, I again have no choice but to be pessimistic about our society's determination to control child abuse. Our society has taken some tentative steps to correct environmental pollution. It has done precious little to correct the social pollution of many Americans' ecologies. It is exactly this polluted ecology that drives many parents to child abuse. So long as we attend only to the symptom of child abuse and engage in the tokenistic efforts flowing from this narrow concern, so long can we avoid dealing with its underlying social determinants which would be much more costly to correct.

The ecological approach does direct us to certain aspects or institutions in the family's ecology where some effort might have particularly high payoff in terms of reducing the incidence of child abuse. In view of the finding that abused children are often the product of an unwanted pregnancy, programs directed towards family planning should be effective in reducing the incidence of child abuse. Another feature of a social support system which would have a direct and immediate effect on the reduction of child abuse is homemaker services, which could aid in the child-rearing function of families who are experiencing difficulties. This generates one of the general conclusions of my analysis, namely that the control of child abuse is much more likely to come from efforts to beef up our nation's general social service programs than it will come from efforts specifically directed against child abuse.

Another feature of the ecology important in determining the incidence of abuse is the availability of child care. A logical consensus has developed that the incidence of child abuse would be reduced if parents could more readily avail themselves of child care of various kinds. However, our society appears to be extremely reluctant to provide the child care that so many American families need desperately. It is only my dislike for hyperbole which prevents me from shouting hypocrisy at a society which says it wants to control child abuse and yet does so little to provide families with child care.

We come now to the single most important determinant of child abuse, namely the willingness of adults to inflict corporal punishment upon children in the name of discipline. Well over half of all instances of child

abuse appear to have developed out of disciplinary action taken by the parent. All too often an adult begins to discipline a child and ends up damaging the child much more than was intended. This situation is exacerbated by the parent's lack of knowledge about the physical vulnerability of the child.

We might ask ourselves who is the real villain in this common scenario? Certainly not the child. Nor is it the parent who often feels that he is doing what society expects of him in providing discipline for his child. No, the real villains are those child-rearing practices which permit the corporal punishment of children and a society which approves such a method of child discipline. I add my voice to those of many others and assert that so long as corporal punishment is accepted as a method of disciplining children, just so long will we have child abuse in our country. It is this central point being made here that once again leads me to be pessimistic about our nation's ability to control child abuse.

Again I am tempted to point out the hypocrisy of a society that verbalizes its desire to stop child abuse but is nevertheless willing to countenance the legal abuse of children residing in physical settings funded with taxpayers' dollars. I refer here to the well-documented abuse and neglect of children occurring in institutions for the retarded, hospital settings for emotionally disturbed children, and within our nation's day care system. This abuse of children is being purchased with your tax dollars and mine. I have looked closely at who is guilty of child abuse and have thus discovered that it is me.

Where else may we find the legally and socially sanctioned abuse of children? I point to that social institution which, after the family, is the most important socializing agent in America, namely the school. A family's ecology is best conceptualized as a rubric of interacting social institutions. The school is an important institution embedded in this rubric, and its practices not only reflect the values of America's families but also influence the development of familial attitudes and practices. If you wish to decrease the incidence of child abuse in America, make it illegal for school personnel to apply corporal punishment against school children under any circumstance. In this regard I am troubled by the Supreme Court's recent decision upholding the right of school personnel to physically punish children. As a result of the example such punishment sets, it makes much more likely the abuse of children in the home, where the more severe forms of child abuse currently take place.

This era of violence in the schools should not be attributed to an under-use of disciplinary measures in the home. It appears rather to reflect a growing acceptance of violence in our society. One finds violence, hostility, and aggression everywhere in our society, and so long as these are tolerated and even glorified so long can we expect the abuse of children both at home and in school.

It is the total foregoing analysis which leads me to conclude that we will make little progress over the next few years in reducing the incidence of child abuse. We simply do not have the knowledge and resources to deal very effectively with even the symptomatic treatment of child abuse in our society. I must also inform you that I even find myself conflicted about the value of the Child Abuse Prevention and Treatment Act of 1974. The Act simply promises more than it can possibly deliver. The bill provides too little in the way of resources and direction for us to make any significant impact on our child abuse incidence figures. We cannot legislate away major social

problems like child abuse with a single bill. Social change is produced not by the stroke of a pen but by intensive and persistent efforts to change the human ecology within which the social target is embedded. Laws such as the Child Abuse Act do little more than give us a false sense of security. Such tokenistic efforts give the appearance that something meaningful has been done and thus interfere with the mounting of truly effective measures. A 20 million dollar bill to fight child abuse in America amounts to little more than putting a band aid on a cancer. However, given the current fiscal austerity in our nation, I am afraid for the time being that child abuse will have to take its place alongside lead paint poisoning (which by the way is another socially tolerated form of child abuse) as another problem which our society has neither the commitment nor the resources to solve.

I must confess that I am surprised at the depth of my pessimism concerning our nation's ability to reduce the incidence of child abuse. This pessimism should not be misinterpreted as some sort of plea for adopting a stance of apathy or inaction. There is much that could and should be done in this area including (1) an invigorated research and data collection program, (2) increased efforts in the family planning area, (3) the widespread implementation of education for parenthood programs, (4) a massive effort to reduce the number of premature births in America, (5) an increase in the availability of homemaker services, and (6) the immediate increase in the availability of child care in America. Finally and perhaps most importantly, we will need a willingness to examine our society's value system and a commitment to reduce the acceptability of man's violence to man, of which child abuse is but one manifestation.

Effects of Preinstitutional History and Institutionalization on the Behavior of the Retarded

I am going to talk today about the implications of a long-standing research interest and commitment on my part: the impact of institutional experience on the behavior and development of retarded persons. As will soon become clear, much less is known about the impact of institutions than would be expected, considering the importance of the issue. Reliable knowledge concerning the effects of institutions is important for several reasons. At a theoretical level, many investigations of the behavior of the retarded have involved comparisons of noninstitutionalized normal individuals and institutionalized retarded individuals. In this kind of study it is impossible to determine what effects are attributable to institutionalization and which effects are attributable to mental retardation per se. Indeed, several of my colleagues are now trying to separate these two factors.

Secondly, increased knowledge about the effects of institutions would be extremely helpful to parents and professionals. The decision whether or not to institutionalize a retarded person is one of the most painful that parents can face. Many professionals hold strong views on this subject but they are often contradictory or too simplistic. Depending on the expert approached, a parent might be informed that the degree of retardation is such that institutionalization is the only possible solution, that institutionalization is necessary so that the development of the other children in the family not be prejudiced, or that institutionalization should be avoided at all costs because it is either unnecessary or so demeaning to the retarded person that no parent should permit it. If the effects of institutions were known, a great deal of conflict and pain on the part of the parents would be alleviated.

Perhaps of greatest importance, though, is that reliable knowledge concerning institutionalization effects would be extremely helpful in informing social policy in the field of mental retardation. I especially have in mind here the question of large central institutions versus community-based regional centers or group homes. For almost 15 years now, the predominant thrust of social policy in the mental retardation area has been a movement away from large central institutions to a community-based regionalization model in which the retarded are treated in the community in small residential settings. This social policy has evolved almost completely without an empirical base. The almost total lack of data on what constitutes the most adequate care setting for the retarded is potentially disastrous for those involved in the creation of social policy, whatever their persuasions as to what is the best care setting. For example, in this day of drastic budget-cutting at all levels of government, I think that it is entirely possible that the large central institution will be rediscovered. After all, expensive professional services can be consolidated, there would be savings in administrative costs, and the economies of scale would operate. If policy-makers cannot demonstrate that regional centers or group homes are cost-effective, it would be difficult to resist such arguments for central institutions.

With this background as to the importance of the issue, I will talk about the program of research conducted by myself and my collaborators for almost 20 years now. To anticipate a bit, we have become convinced that

any comprehensive understanding of the effects of institutionalization must require a consideration of three classes of variables. The first is the characteristics of the person. The effects of institutionalization have been found to be different as a function of such factors as the person's sex, his diagnosis, his developmental level, and his chronological age. Of particular importance is the preinstitutional life experience of the individual. We have found again and again that a retarded person's response to institutionalization is partially determined by the nature of his experiences prior to institutionalization.

The second important class of variables concerns the nature of the institution. Here we have found that it is crucial to go beyond the simple question of size. We must look at other demographic variables, such as cost, number of staff per resident, and employee turnover rate. We must go even further than this examination of multiple demographic variables and investigate the social-psychological characteristics of institutions, their administrative structure, employee attitudes, and the actual way in which the residents are cared for. Let me say at the outset that we consider this class of variables to be especially important. The view that institutions with enlightened administrators, with employees with positive attitudes concerning the retarded, and with humane care-taking practices will promote more adequate adaptation and competence in the residents is certainly a plausible one. However, we feel that investigations concerned with the quality of life of the retarded are valuable in and of themselves. The retarded have a right to humane care and treatment whether or not such care ultimately results is greater behavioral growth. The final class of variables of importance is, of course, measures of the behavioral status and growth of retarded individuals, including both cognitive and motivational factors.

My own work with institutional effects can be traced back to my doctoral dissertation. In this study I was interested in the phenomena of perseveration and dependency so often seen in the institutionalized retarded. Based on the work of Kurt Lewin, it was widely believed at the time that this perseveration was somehow an inherent characteristic of the retarded. I took an alternative view. I hypothesized that many of the institutionalized retarded had been deprived of supportive contact with adults both before they were institutionalized and while they were in the institutions. Consequently, I believed that they would be extremely responsive to supportive contacts with adults when they were available. I viewed perseveration as being a consequence of such a heightened responsiveness to social reinforcement. To test this idea, I had a group of retarded individuals who had been institutionalized for approximately two years play an extremely boring and repetitive game involving simply dropping marbles in the hole of a box. However, when they dropped the marbles they were frequently told that they were doing very well. In addition, I tried to make the situation as pleasant as possible by smiling and nodding frequently. I asked two experienced clinical psychologists to rate the social histories of the individuals as to how much deprivation they had experienced before coming to the institution. I found that people who had been rated as more deprived persevered longer on the marble-dropping game than individuals rated as less deprived. It seemed that the perseveration seen in the retarded was due to a lack of contact with supportive adults rather than somehow being intrinsic to mental retardation. I've found additional support for this view in a study of responsiveness to social reinforcement in institutionalized and noninstitutionalized normal and retarded children. The institutionalized normal children were just as responsive to social reinforcement as the

institutionalized retarded children. There were also no differences between the noninstitutionalized normal and retarded groups.

At this point, my interest in institutionalization led me in several different directions. Probably the most important was the choice of a research strategy which has been characteristic of my work for many years – that is, the longitudinal study. It's probably apparent to many of you that there are difficulties in any study involving institutionalized persons on a one-time basis. If the behavior of the institutionalized retarded is found to be different from that of the noninstitutionalized retarded, we really have difficulty in saying that these differences are solely due to the effects of institutionalization. It may be that individuals who are institutionalized are different in many crucial respects from those who remain in their homes. Consequently, I early come to believe, along with others, such as Professor Tizard, that longitudinal studies are necessary in order to fully understand the effects of institutions. When the growth of a group of individuals is mapped over time, we can be on more confident grounds in attributing any changes to the effects of institutional experience.

The first longitudinal study was conducted in collaboration with Joanna Williams. In this study, the individuals that were tested in my dissertation were retested after three additional years of institutional experience. In addition to changes in responsiveness to social reinforcement on the measure that I talked about before, we also looked at changes in IQ test scores. We found that, over the three year period, individuals as a group became significantly more motivated to receive the attention and support of a friendly adult. However, the increase in motivation for social reinforcers was related to the amount of preinstitutional deprivation that the individuals had experienced. Individuals who came from relatively good homes showed a much greater increase in their motivation for social reinforcers than did individuals coming from more socially deprived homes. It seemed that the effects of institutionalization depended on the preinstitutional history of the individual, with such institutionalization being more socially depriving for individuals from relatively good homes than for individuals from extremely deprived backgrounds.

We were surprised to find a general decrease in IQ between the first and second testing. We also discovered that this finding was reminiscent of those in a study of the Clarkes in England. These investigators discovered that individuals coming from extremely poor homes showed an increase in IQ following institutionalization, with no increase observed in individuals coming from relatively good homes. Indeed, in the Zigler and Williams study, the only persons showing increase in IQ were in the highly deprived group, as defined by the clinical psychologists who had rated the social histories.

In collaboration with Earl Butterfield and Frances Capobianco, we studied these same individuals after seven years and after 10 years of institutional experience. After both seven and 10 years of institutionalization, highly deprived individuals became much less responsive to social reinforcement than did less deprived individuals. This finding certainly supported the view that institutionalization was less depriving for individuals from poor homes than for individuals from good homes. Even more important was our discovery that the effects of preinstitutional social deprivation were still in evidence after 10 years of institutionalization. It would be difficult to overemphasize the importance of this point. Social deprivation is a phenomenon that, once experienced, becomes built into the motivational structure of the individual and subsequently mediates his interactions with his environment.

At about this time, we conducted another longitudinal study of changes in responsiveness to social reinforcement and IQ in a group of institutionalized retarded persons. The first of these studies was conducted in collaboration with David Balla and Earl Butterfield. We tested individuals approximately three weeks following institutionalization and then again approximately three years after institutionalization. The individuals were placed in what was considered to be one of the finest public institutions in the country. In contrast to the findings in the Zigler and Williams study, the individuals in this institution became less responsive to social reinforcement over three years and increased in IQ. Furthermore, individuals from relatively good homes showed a smaller decrease in responsiveness to social reinforcement than did individuals from relatively poor homes. It seemed most reasonable to conclude that the differences in findings between the two studies were due to the differences in the quality of the two institutions. It seemed that the institution employed in the first study was a depriving one, while the one employed in the second study actually ameliorated the effects of preinstitutional deprivation. In a further study of this group of individuals, we found that after six years of institutional life the tendencies towards psychological growth found after three years were still in evidence. There was a further significant increase in IQ, while the individuals' responsiveness to social reinforcement stabilized. Just as in the Zigler, Butterfield, and Capobianco study, the effects of preinstitutional life experience were still in evidence after six years, in that organically retarded subjects who came from homes characterized by marital discord and/or mental illness were more responsive to social reinforcement over all six years than less deprived organically-retarded subjects.

In collaboration with David Balla, I then conducted a study of the developmental course of responsiveness to social reinforcement in institutionalized retarded children and noninstitutionalized normal children. Groups with mental ages of approximately seven, nine, and 12 were investigated. We found that both retarded and normal children of higher mental ages were less responsive to social reinforcement than those of lower mental ages. This finding was certainly consistent with a common observation that children become less dependent and more autonomous as they grow older. However, at every mental level the retarded subjects were far more dependent than their normal counterparts. There was no tendency for the retarded individuals to catch up in their autonomy as they became older. In fact, the oldest retarded group persisted at the Marble-in-the-Hole game almost twice as long as the youngest normal group. Thus, the institutionalized retarded child seems to be severely deficient in the development of the reliance upon internal resources which determines much of his effectiveness in the adult world.

As in our previous studies, we found that those individuals who had experienced greater preinstitutional social deprivation were more responsive to social reinforcement than less deprived children. Of special interest was our finding that the retarded individuals who maintained contact with their parents or parent-surrogates either by being visited at the institution or by going home on vacations were more likely to display the type of autonomous behavior characteristic of normal children. Thus, we found clear empirical evidence that an institutional policy of encouraging many contacts with the preinstitutional environment does promote psychological growth.

By this time, we were demonstrating in our research that the effects of institutionalization are extremely complex, dependent on the individuals'

preinstitutional life experience and the particular institution under consideration. While this point should almost be self-evident, it is all too often overlooked. Institutions for the retarded continue to be seen as uniform entities producing monolithic behavioral consequences.

As it became increasingly apparent that there were important differences between institutions, it was clear that we should conduct cross-institutional studies. The first of these I did in collaboration with Earl Butterfield. Two of the nearby large central institutions with which we were familiar impressed us as having very different social climates. In the first institution, every effort was made to provide a homelike atmosphere. No buildings were locked and all of the residents could freely move around the grounds. The first was organized on a cottage system with a large number of small residential units. In the second institution, little effort was made to provide a homelike atmosphere. The residents ate in a large central dining room with virtually no individual supervision. All of the buildings were locked and no individual could move around the grounds unattended by an employee. The institution was organized on a dormitory system with very large living units. We felt that the second institution was much more socially depriving than the first one and the effects of such deprivation would be seen in the responsiveness to social reinforcement of the individuals. Indeed, this was just what we found. Individuals in the more depriving institution persisted longer on our measure of response to social reinforcement.

The next cross-institutional study, which I did with David Balla and Earl Butterfield, was a good deal more ambitious. We used a longitudinal design and investigated four institutions in different parts of the country. In this study, we tried to take a much more fine-grained look at the nature of the institutions. We gathered data on size, number of residents per living unit, cost per resident per day, employee turnover rate, number of direct care personnel per resident, number of professional staff per resident, and number of volunteer hours per resident per year. We felt that an examination of these factors, in conjunction with our general impressions, would provide a reasonable framework from which to evaluate behavior change on the part of the residents. Indeed, the institutions varied in size from approximately 400 to approximately 2,000 residents. There was also considerable variation in cost, number of aides per resident, and employee turnover rate.

We examined residents in each of the institutions within six months of their admission date, and again after two and one-half years of institutional experience. In addition to the measure of responsiveness to social reinforcement that we had used in previous studies, we also obtained measures of mental age, IQ, verbal dependency, extent of imitation of adults, and variability in behavior. Contrary to our most pessimistic views concerning the effects of institutionalization, we found considerable evidence of psychological growth on the part of the residents. Over the course of two and one-half years in all of the instituions, the residents became less verbally dependent, less imitative, and more variable in the behavior. IQ level did not change and mental age level increased. To our surprise, very few of the findings were related to any of the characteristics of the institutions. Residents in the largest of the institutions were more responsive to social reinforcement than residents in the other three institutions. With this exception, none of the other demographic characteristics of the institutions were found to be related to the behavior or development of the residents. Our subjective impressions were equally inaccurate in relating to the behavior or the development of the residents. At this point, it seemed clear to us that an even more fine-grained measure of institutional characteristics was needed.

We were extremely fortunate in that King, Raynes, and Tizard, in England, had conducted extensive and sensitive cross-institutional studies of resident care practices in institutions for the retarded. These investigators developed a Resident Management Practices inventory which we thought was an excellent measure of the social-psychological characteristics of the institutions. This inventory was conceptualized as tapping institution-oriented care-practices, at one extreme, versus resident-oriented practices at the other. In their view, the items in the inventory could be grouped along four dimensions. The first they called rigidity of routine and concerned the inflexibility of management practices, so that, at one extreme, neither individual differences among residents or unique circumstances are taken into account by the staff in their interactions with resident. The second dimension was called block treatment and concerned the regimentation of residents before, during, and after specific activities, such as meal time. The third dimension was referred to as depersonalization, a measure of the presence or absence of opportunities for residents to have personal possessions, privacy, or situations allowing self-expression and initiative. The fourth dimension was referred to as social distance and concerned the limitation of interaction between staff and resident to formal and specific activities and the use of physically separate areas of congregation between the residents and those who cared for them.

Using this inventory, the English group investigated three types of facilities for the retarded: mental deficiency hospitals, ranging in size from 121 to 1,650 residents; voluntary homes, ranging in size from 50 to 93 residents; and local authority hospitals, ranging in size from 12 to 41 residents.

The care practices were found to be more resident- as opposed to institution-oriented in the group homes and more institution-oriented in the mental deficiency hospitals. The voluntary homes fell between the hospitals and group homes. Of particular interest was the finding that, once type of institution was taken into account, there was no tendency for management practices to be associated with institution size. In other words, type of institution, rather than size of institution, was the important determinant of care practices. The importance of this point is underscored when you recall that the mental deficiency hospitals ranged in size from approximately 100 residents to approximately 1,600 residents, yet no differences in care practices were found within this type of institution. When type of institution was taken into account, no association was found between the number of residents in each living unit and the care practices observed. Neither was a relationship found between resident-to-staff ratios and care practices. Finally, the English group found that the level of retardation of residents in the individual living units was not an over-riding determinant of care practices. This result was of some surprise to us in view of the findings of such people as Bell and Yarrow that child-rearing practices are as much determined by the characteristics of the child as by the characteristics of the adult. More severely retarded children are less responsive and provide less feedback than children of higher cognitive competence. It would seem quite easy to become mechanical and unresponsive while caring for children when responsiveness to such care is not immediately evident.

We felt that the investigations of the English group were important for several reasons. First, they studied different types of institutions at a time when far too little attention had been paid to the relative adequacy of central institutions, regional centers, and group homes. Secondly, they were

directly concerned with the quality of life of the institutionalized retarded, a matter which has been grossly neglected in empirical research. Finally, these investigators underscored the importance of the living unit as the appropriate unit analysis.

We decided that just such a study was needed for institutions in the United States. We were also quite fortunate in having the opportunity to study institutions in a Scandinavian country world-renowned for its humane care of the retarded. In collaboration with Mark McCormick and David Balla, I studied the resident care practices in 166 living units from 19 institutions in the United States and 11 institutions in the Scandinavian country. We also examined a number of institutional demographic variables: institution size; average number of residents per living unit; cost per resident per day; number of aides per resident; number of professional staff per resident; annual employee turnover rate; volunteer hours per resident per year; and mean institutional IQ. We also obtained additional information for each living unit studied: the level of retardation in each unit, that is, mild, moderate, or severe-profound, and the age level of the residents in each unit, that is, child, adolescent, or adult.

We found that living units in the Scandinavian country were more resident-oriented than living units in the United States. In both countries, large central institutions were characterized by the most institution-oriented care practices and group homes by the most resident-oriented care practices, with regional centers falling between these extremes. This finding was consistent with that of the English group. Contrary to the views of the English workers living units for more severely retarded residents were found to be more institution-oriented. We then went on to see if we could determine which of the demographic variables were most closely associated with care practices. We employed multiple regression analyses, with the demographic characteristics of both institution and individual living unit as predictor variables and the Resident Management Inventory as the dependent variable. The findings of these analyses were particularly interesting. Large living unit size and level of retardation were found to be predictive of institution-oriented care practices. Cost per resident per day, number of aides per resident, or number of professional staff per resident, *did not* predict care practices.

The lack of association of either financial, as measured by cost per resident per day, or human, as measured by number of aides and professional staff per resident, factors came as a considerable surprise to us. Apparently, simply increasing expenditures or personnel will not necessarily guarantee better care for the retarded. Rather, it is how these personnel are utilized in the settings in which they are found. The finding that living unit size was predictive of care practices is of special practical interest here. One way of creating more humane settings for the institutionalized retarded may well be to design living units small enough that each resident is, of necessity, seen as an individual. It is encouraging to note that it may be possible to pursue such a policy with existing resources. You will recall that the most resident-oriented care practices were found in group homes. The group homes were operated at less cost than either the regional centers or the large central institutions. It may well be that part of the lower cost of group homes can be accounted for by the fact that these facilities, for the most part, serve mildly retarded residents who require less care and supervision. However, as I mentioned above, number of aides or professional staff per resident were not found to be predictive of care practices.

We did find one exception to the general lack of association of such "human variables" as number of aides per resident and aide turnover rate and care practices. In group homes in the United States, low aide turnover rate and a high ratio of professional staff per resident was found to be predictive of more resident-oriented care practices.

The results of this study, as well as the findings of the English investigators, convinces us that we had a sensitive method of characterizing the social-psychological milieu of residential settings for the retarded. What was lacking in both our work and in the work of the English group was a study in which both care practices and the actual behavior of the residents were investigated. In collaboration with David Balla and Nancy Kossan, such a study was conducted. We examined a total of 114 retarded persons in 20 living units in seven institutions. Five of the facilities were regional centers and two were large central institutions. In each living unit, the Resident Management Practices Inventory of the English group was administered to the charge aide. We also obtained a measure of attitudes concerning the retarded from each aide in each living unit. We looked into such institutional demographic variables as cost per resident per day, aide turnover rate, and number of aides per resident. The association of preinstitutional life experience, chronological age, mental age, IQ, sex, and length of institutionalization with behavior was also examined. On the behavioral side, we obtained indices of responsiveness to social reinforcement or dependency, wariness of adults, and imitation. Our previous work has suggested that these three factors are particularly important in retarded individuals' daily competence.

Before talking about our findings concerning the determinants of the behavior of the subjects in the study, I want to mention one major result with the demographic institutional variables. Large institution size was found to be very significantly related to larger living unit size, to high employee turnover rate, to low cost per resident per day, to a low ratio of aides to residents, to a low proportion of professional staff to resident, to a low number of volunteer hours per resident per year, to more adverse opinions concerning the retarded, and to more institution-oriented care practices. This pattern of interrelationships is especially important in discussions concerning social policy and residential facilities. Such discussions most often focus solely on institution size. If our findings have generality beyond the state in which the study was conducted, they could as easily focus on lack of professional staff, lack of aides, or lack of continuity of care, as measured by turnover rate. We should certainly display considerable caution when interpreting relationships between institution size and some other variable, since any such empirically discovered relationship may be due to the common relationship that these two measures have with a third measure.

Turning now towards findings concerning the behavior of the retarded individuals, we found no differences between persons residing in central institutions and persons residing in regional centers on any of our behavioral measures. This lack of findings as of some surprise in view of the fact that the average size of the large central institutions was 1,633, while the average size of the regional centers was 111. The central institutions also housed more residents per living unit and had a higher aide turnover rate. The cost per resident per day was twice as high in the regional centers than in the central institutions. The number of aides per resident was twice as

high in the regional centers than in the central institutions. The proportion of professional staff per resident and the number of volunteer hours per resident per year was almost six times as great in the regional centers than in the central institutions. Such findings lend credence to the view that simply increasing cost and/or increasing staff will not, in and of itself, insure greater behavioral competency on the part of residents in institutions. The findings also suggest that more intensive efforts need to be made to discover what particular experiences or programs enhance the behavioral competency of residents in institutions. The mere placement of a retarded person in a regional center did not seem to suffice as a means for increasing competency.

Essentially, no behavioral differences were found between persons residing in the two central institutions or the five regional centers. There were also no behavioral differences between persons residing in the largest regional center, with a population of 290, and the smallest regional center, with a population of 12. It seems most reasonable to conclude that the behavior of the residents in all of the institutions was similar.

We then went on to do a series of multiple regression analyses in which all of the characteristics of the residents, for example, mental age or length of institutionalization, and all of the institutional characteristics, for example cost per resident per day or resident management practices score, were used to predict the scores on our measures of behavior. I should note that in this kind of analysis, the effect found for any one variable is independent of the effects of all other variables.

We found that several of the characteristics of the institutions were associated with the behavior of the residents. The larger the size of the institution, the greater was the motivation of the individuals to receive adult attention and support. In large institutions, individuals appear to be relatively deprived of this class of social reinforcer. It should be noted that this finding was the single instance in which institution size was predictive of the resident's behavior. To this point, we had been assuming that depriving socializing experiences lead retarded individuals to be excessively dependent upon adults when the adults are reinforcing their behavior by making supportive comments. However, there is a body of work in the tradition of Spitz and Bolby that suggests that extreme forms of deprivation can result in apathy, withdrawal, and a lack of responsivity to supportive adults. It seems as though, in order to develop attachments to adults and thus become responsive to their attention and support, the child must have some minimal number of positive encounters with them. Children extremely deprived of such encounters would be expected to show greatly attenuated responsivity to adult attention and support. On the other hand, if children experience some minimum of support and attention at the hands of adults within a general socializing history of deprivation, we would expect these children to show atypically high responsivity to attention and support. We found some support for this formulation in this study. Large professional staffs and active volunteer programs were found to be associated with higher responsiveness to social reinforcement.

We found considerable evidence that depriving socializing conditions produce wariness of adults. The larger the number of individuals in a living unit, the greater the wariness of the individuals who lived in the unit. Increased wariness was found in settings with high employee turnover rates and a high proportion of aides to residents. Thus, it would seem that the response to a large number of non-continuous adults caretakers, and therefore non-predictable adult care-taking, is the development of wariness. We also found that adverse attitudes concerning the retarded, by the aides, was related to greater wariness on the part of the residents.

We found some evidence suggesting that some institutions socialize their residents in the direction of reduced behavioral spontanaity and/or conformity. We found high levels of imitation in individuals institutionalized a relatively long period of time and in individuals who were the recipients of institution-oriented, as opposed to resident-oriented, care practices. Thus, many of the institutionalized retarded appear to live in a highly predictable environment which emphasizes conformity. Such conformity may be a form of adjustment to the institution. The value of living in a well organized and predictable environment can be seen in a finding that less wariness was displayed by residents receiving institution-oriented as opposed to resident-oriented care-taking practices. However, such conformity was probably purchased at too high a psychological cost. The conforming and imitative child distrusts spontaneous solutions to problems and may be ill-equipped to function in the much less organized and predictable environment outside the institution.

We have come to view either too little or too much imitation as negative psychological indicators with some intermediate level of imitation being viewed as a positive developmental phenomenon reflecting a person's healthy attachment to adults and responsivity to cues that adults emit which can be used in problem-solving efforts. Consistent with this view was our finding that retarded individuals whose care-takers had negative attitudes concerning them were less imitative. Persons consistently reacted-to in a negative manner may respond by ignoring the cues provided by adults and thus become less imitative.

In addition to these effects of the institutions upon behavior, we found several characteristics of the persons to be predictive of their behavior. Consistent with earlier findings, residents of high mental age were found to be less motivated for social attention and support than were residents of low mental age. Thus, retarded children, like their peers of average IQ, seemed to move from dependency to autonomy as their cognitive level became higher. Evidence was also found indicating that the higher the mental age level, the greater the wariness. This finding would appear to be consistent with that body of work indicating that the higher the developmental level of the child, the greater his sensitivity to depriving events and his capacity to construct such self-defeating mechanisms as wariness and avoidance of adults. Consistent with earlier findings, mental age was found to be negatively related to imitation. This finding was in keeping with two facets of my outerdirectedness formulation. The higher the cognitive level of the child, the less the child employs imitation in his problem-solving efforts and the lower the IQ of the child, the more failure experiences the child has when employing his own cognitive resources and, thus, the greater tendency for imitativeness.

Finally, we found that individuals who had experienced frequent changes of parenting figures before they were institutionalized were both more motivated to attain the attention and support of an adult but were more wary of doing so. These findings provided additional evidence for my view that deprived retarded individuals have both atypically high positive and negative reaction tendencies. The subjects in this study had been institutionalized for an average of over eight years and the fact that the effects of pre-institutional life experience were still in evidence after so long a time is consistent with my general position that social deprivation experienced relatively early in life can affect the behavior of the retarded when it is assessed many years later.

I am continuing my work on the effects of institutional living on the behavior and development of the retarded, paying especially close attention to the social policy implications of the work. I am also continuing investigations concerning the quality of life of the institutionalized retarded. In collaboration with David Balla, I am conducting a five year longitudinal study of the development of residents in central institutions, regional centers, and group homes. I am also conducting a study of discharge rates and success in community placement in residents in central institutions and group homes. I hope that the final result of this research program will be determination of the optimal residential setting at the optimal cost.